Respiratory Care Board of California
444 North 3rd Street, Suite 270, Sacramento Ca 95814
Telephone: (916) 323-9983 Toll Free: (866) 375-0386 Fax: (916) 323-9999
Website: www.rcb.ca.gov E-mail: rcbinfo@dca.ca.gov

CONSUMER COMPLAINT FORM

Complainants are immune from prosecution for registering complaints pursuant to Business and Professions Code Sections 2318, 3759 and Civil Code Section 43.8.

PERSON REGISTERING COMPLAINT

FULL NAME		
BUSINESS NAME (if applicable)		
ADDRESS (Business or Residence)		
TELEPHONE NUMBERS	**Home: ( )**	**Work: ( )**

Would you like this information to remain confidential, for use by the RCB only? ❑ ***Yes*** ❑ ***No***
Do you want to remain anonymous? ❑ ***Yes*** ❑ ***No***

COMPLAINT REGISTERED AGAINST

SUBJECT'S FULL NAME		
RCP NUMBER		
BUSINESS NAME OR EMPLOYER		
BUSINESS ADDRESS		
TELEPHONE NUMBERS	**Home: ( )**	**Work: ( )**

WITNESS INFORMATION

If there were any witnesses to the incident, please provide the following information.

WITNESS NAME:	**WITNESS NAME:**	**WITNESS NAME:**
TITLE:	**TITLE:**	**TITLE:**
PHONE #:	**PHONE #:**	**PHONE #:**
BUSINESS:	**BUSINESS:**	**BUSINESS:**
ADDRESS:	**ADDRESS:**	**ADDRESS:**

LOCATION & DATES OF INCIDENT

LOCATION OF INCIDENT	❑ **Hospital** ❑ **Home** ❑ **Other** _____
ADDRESS OF INCIDENT	
DATE(S) OF INCIDENT	

RELATIONSHIP TO THE SUBJECT

❑ **PATIENT** ❑ **CO-WORKER** ❑ **RELATIVE** ❑ **EMPLOYER** ❑ **OTHER** _____

PLEASE COMPLETE REVERSE SIDE

DESCRIPTION OF INCIDENT

INCIDENT REPORTED TO OTHER ENTITIES

Was the incident reported to anyone else? If yes, provide name, phone number, date reported, and action taken.

NAME:	**NAME:**
PHONE #:	**PHONE #:**
DATE REPORTED:	**DATE REPORTED:**
ACTION TAKEN:	**ACTION TAKEN:**

▸ ***Please attach any documents supporting your allegations.***

I certify under penalty of perjury that the foregoing statements made by me are true and any documents attached are true copies. I am aware that if any statements made by me are willingly false, I am subject to penalties under the laws of the State of California.

Signature _____ Date _____

NOTICE ON COLLECTION OF PERSONAL INFORMATION

Collection and Use of Personal Information. The Department of Consumer Affairs, Respiratory Care Board collects the information requested on this form as authorized by Business and Professions Code Sections 325 and 326. The Respiratory Care Board uses this information to follow up on your complaint.

Providing Personal Information Is Voluntary. You do not have to provide the personal information requested. If you do not wish to provide personal information, such as your name, home address, or home telephone number, you may remain anonymous. In that case, however, we may not be able to contact you or help you resolve your complaint.

Access to Your Information. You may review the records maintained by the Respiratory Care Board that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Infomation.

We make every effort to protect the personal information you provide us. In order to follow up on your complaint, however, we may need to share the information you give us with the business you complained about or with other government agencies. This may include sharing any personal information you gave us.

The information you provide may also be disclosed in the following circumstances:

- In response to a Public Records Act request, as allowed by the Information Practices Act;
- To another government agency as required by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

Contact Information. For questions about this notice or access to your records, you may contact the Respiratory Care Board at 444 North 3rd Street, Suite 270, Sacramento, CA 95814, (866) 375-0386, or email rcbinfo@dca.ca.gov. For questions about the Department of Consumer Affairs' privacy policy or the Information Practices Act, contact the Office of Privacy Protection, 1625 North Market Blvd., Sacramento, CA 95834, (866) 785-9663, or e-mail privacy@dca.ca.gov.

State of California
Department of Consumer Affairs
Respiratory Care Board

AUTHORIZATION FOR RELEASE

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

I, the undersigned, hereby authorize the following to disclose records in the course of my diagnosis and treatment to the Respiratory Care Board of California.

1. _____
_____
_____

2. _____
_____
_____

3. _____
_____
_____

4. _____
_____
_____

5. _____
_____
_____

6. _____
_____
_____

The disclosure of records authorized herein is required for official use including investigation and possible proceedings regarding any violations of the laws of the State of California.

This authorization shall remain valid until the Respiratory Care Board of the State of California completes its investigation and proceedings arising out of the investigation.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

Signature _____ **Date** _____
Patient

OR

Signature _____ **Date** _____
Representative

Relationship to Patient _____